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JAMES W. HOLSINGER, JR., M.D.
SECRETARY

February 18, 2004

Community Mental Health Centers
Provider Letter # A-65

Dear Community Mental Health Center Provider:

This letter is to inform you of two emergency regulations in effect at this time. The following is a summary for 907 KAR 1:045E, Payments for Community Mental Health Centers and 907 KAR 3:170E, Telehealth Services and Reimbursement.

907 KAR 1:045E became effective October 1, 2003 and allows for adjusted payments to the CMHCs for services provided to Medicaid recipients. These adjusted payments will be for services provided for the period of October 1, 2002, through June 30, 2004. The plan for achieving the adjusted payments is detailed below.

The contract between the Department for Mental Health and Mental Retardation Services and the Community Mental Health Centers include an allocation for community care support, which is intended to provide funding for individuals who do not have any other payor source. The cabinet will take a portion of this allocation and it will be paid as the adjusted payment from the Department for Medicaid Services. For state fiscal years 2004 and 2005, your contract will not be amended to remove any funds, but your payments from DMHMRS will be reduced by an amount equal to the adjusted payment. The electronic payments you receive from DMHMRS will be reduced on a monthly basis, beginning in September 2003.

Medicaid began making the adjusted payments in the fall of 2003, with quarterly payments thereafter. The first payment you received from Medicaid was calculated based on services provided during the period of October 1, 2002, through September 30, 2003. The December, March and June payments will be for services provided during the corresponding quarters. The adjusted payments will be subject to the same restrictions and requirements as if paid by DMHMRS.

907 KAR 3:170E Telehealth Services and Reimbursement became effective December 1, 2003 and allows for reimbursement for Community Mental Health Centers to provide telehealth services to Medicaid recipients. A telehealth service for a licensed CMHC will be limited to twelve (12) psychiatric services, provided by the center's psychiatrist or ARNP, per recipient, per year. The telehealth service will be billed using the following diagnostic CPT service codes and a GT modifier:

1. 90801 for a diagnostic interview examination;
2. 90862 for medication management;
3. 90887 for an outpatient collateral;
4. 90804 for an individual psychotherapy; or
5. 90847 for an outpatient family therapy.

Unisys, fiscal agent for Kentucky Medicaid, is sending a letter to the CMHC providers with billing instructions for the telehealth services. This letter will also contain billing instruction corrections, an updated procedure code crosswalk, and an updated modifier listing for the new procedure codes and modifiers that were initiated on 10-16-03. A list of the procedure codes and modifiers can also be accessed on the following website: http://chs.ky.gov/dms/.

We appreciate and value your participation in the Medicaid program, and the services you provide recipients. If you have any questions regarding this letter, please contact Jennifer Smith, R.N., Division of Medicaid Services for Mental Health/Mental Retardation at (502) 564-5198.

Sincerely,

Russ Fendley,
Commissioner

CABINET FOR HEALTH SERVICES

Department for Medicaid Services

Division of Medicaid Services for Mental Health/Mental Retardation

(Emergency Amendment)

907 KAR 1:045E. Payments for community mental health center services.

RELATES TO: KRS 205.520(3) and KRS 210.370

STATUTORY AUTHORITY: KRS 194A.030(3), 194A.050(1), 42 CFR 447.325, 42 USC 1396a-d

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health Services, Department for Medicaid Services [~~Human Resources~~] has responsibility to administer the program of Medical Assistance. KRS 205.520(3) authorizes [~~empowers~~] the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes [~~sets forth~~] the method for determining amounts payable by the Medicaid program [~~cabinet~~] for community mental health center services.

Section 1. Community Mental Health Centers. Participating in-state community mental health centers [~~center providers~~] shall be reimbursed as follows:

(1) Effective July 1, 2003:

(a) The payment rate that was in effect on June 30, 2002, for community mental health center services shall remain in effect throughout state fiscal year (SFY) 2004 and there

shall be no cost settling; and

(b) The payment provisions established in subsection (2) shall not apply.

[~~(a) Payment rates for the rate year beginning July 1, 1991 shall be based on the following principles:~~

~~1. Interim (not final) rates for the nine (9) direct service cost centers shall be set based on the latest available cost and statistical data from the mental health centers.~~

~~2. Costs used in setting the interim rates shall be trended to the beginning of the rate year and indexed for inflation to the end of the rate year.~~

~~3. Direct service costs shall be arrayed (the "interim" array) and the interim rate upper limit set at 130 percent of the median cost per unit of service of all participating centers.~~

~~4. The base rate shall be the allowable, reasonable cost for each service unit or the upper limit, whichever is less.~~

~~5. A retrospective final settlement shall be made after the end of the rate year based on the fiscal year ending June 30, 1992 annual cost report. All costs shall be rearrayed (the final array) for the final settlement. For purposes of determining costs in excess of the upper limit, the upper limit shall be the higher of the maximum derived from the interim array or the final array.~~

~~6. Each facility shall have added to its rate, as a cost savings incentive payment, for each direct cost center an amount equal to fifteen (15) percent of the difference between the facility's actual reasonable allowable cost for the cost center and the upper limit based on the final array.~~

~~7. A funding adjustment of fifty-two (52) cents shall be added to the interim outpatient per unit rates, and the same funding adjustment (i.e., the same fifty-two (52) cents) shall~~

~~be allowed as a part of the final outpatient per unit rates (without regard to upper limits) to improve compensation of service providers and encourage provision of additional services.~~

~~(b) Payment rates for the rate year beginning July 1, 1992 shall be based on the following principles:~~

~~1. Interim (not final) rates for the nine (9) direct service cost centers shall be set based on mental health center cost reports submitted for the six (6) month period ending December 31, 1991.~~

~~2. Costs used in setting the rates shall be trended to the beginning of the rate year and indexed for inflation to the end of the rate year.~~

~~3. Direct service costs shall be arrayed and the upper limit set at 130 percent of the median cost per unit of service of all participating centers.~~

~~4. The base rate shall be the allowable reasonable cost for each service unit or the upper limit, whichever is less.~~

~~5. Each facility shall have added to its rate, as a cost savings incentive payment, for each direct cost center an amount equal to fifteen (15) percent of the difference between the facility's actual reasonable allowable cost for the cost center and the upper limit.~~

~~6. A funding adjustment amount (derived by dividing $1.3 million by the number of outpatient units of service) shall be added to the interim rate (without regard to upper limits) to improve compensation of service providers and encourage provision of additional services.~~

~~7. The interim rate shall be adjusted to final prospectively determined rates based on the audited or desk reviewed annual cost reports for the period ending June 30, 1992 with~~

~~the cost reports indexed for inflation, the upper limits previously determined remaining in effect, and the same funding adjustment allowed.~~

~~(c) Payment rates for rate years beginning July 1, 1993 and July 1, 1994 shall be based on the following principles:~~

~~1. Final prospectively determined rates for the direct service cost centers shall be set based on each mental health center's fiscal year ending June 30, 1992 audited annual cost report; if the cost report is not audited at the time of rate setting the rate shall be adjusted upon completion of the audit. Costs shall be actual, reasonable, and allowable costs.~~

~~2. Costs used in setting the rates shall be trended to the beginning of the rate year and indexed for inflation.~~

~~3. Direct service costs shall be arrayed and the upper limit set at 130 percent of the median cost per unit of service of all participating centers.~~

~~4. The base rate shall be the allowable reasonable cost for each service unit or the upper limit, whichever is less.~~

~~5. Each facility shall have added to its rate, as a cost savings incentive payment, for each direct cost center an amount equal to fifteen (15) percent of the difference between the facility's actual reasonable allowable cost for the cost center and the upper limit.~~

~~6. A funding adjustment amount (derived by dividing $1.3 million by the total number of outpatient units of service) shall be added to the rate (without regard to upper limits) to improve compensation of providers and encourage provision of additional services.~~

(2)[~~(d)~~] Payment rates for rate years beginning on or after July 1, 1995 shall be based on the following principles:

1. Final prospectively determined rates for the direct service cost centers shall be set based on each community mental health center's audited annual cost report for the prior year; if the cost report is not audited at the time of rate setting, the rate shall be adjusted upon completion of the audit or desk review. Costs shall be actual, reasonable, and allowable costs.

2. Costs used in setting the rates shall be trended to the beginning of the rate year and indexed for inflation.

3. Direct service costs shall be arrayed and the upper limit set at 130 percent of the median cost per unit of service of all participating centers.

4. The base rate shall be the allowable reasonable cost for each service unit or the upper limit, whichever is less.

5. Each facility shall have added to its rate, as a cost savings incentive payment, for each direct cost center an amount equal to fifteen (15) percent of the difference between the facility's actual reasonable allowable cost for the cost center and the upper limit.

6. A funding adjustment amount (derived by dividing $1.3 million by the total number of outpatient units of service) shall be added to the rate (without regard to upper limits) to improve compensation of providers and encourage provision of additional services.

[~~(2) Payment amounts shall be determined by application of the "Cabinet for Human Resources Community Mental Health - Mental Retardation Reimbursement Manual," dated July 1, 1993, which is incorporated by reference in this administrative regulation~~] ~~and supplemented by the use of the Medicare reimbursement principles. The Cabinet for Human Resources Community Mental Health - Mental Retardation Reimbursement Manual may be reviewed during regular working hours of 8 a.m. to 4:30 p.m. Eastern time in~~

~~the Office of the Commissioner, Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621. Copies may also be obtained from that office upon payment of an appropriate fee which shall not exceed approximate cost.~~]

(3) Allowable costs shall not exceed customary charges which are reasonable. Allowable costs shall not include the costs associated with political contributions, travel and related costs for trips outside the state (for purposes of conventions, meetings, assemblies, conferences, or any related activities), the costs of motor vehicles used by management personnel which exceed $20,000 total valuation annually (unless the excess cost is considered as compensation to the management personnel), and legal fees for unsuccessful lawsuits against the cabinet. However, costs (excluding transportation costs) for training or educational purposes outside the state shall be [~~are~~] allowable costs.

Section 2. Implementation of Payment System. (1) Payments shall [~~may~~] be based on units of service [~~such as fifteen (15 minute or hourly increments, or at a daily rate, depending on the type of service~~]. One unit for each service shall be defined as follows:

Service	Unit of Service
Inpatient Service	15 minutes
Individual Therapy	15 minutes
Group Therapy	15 minutes
Family Therapy	15 minutes
Collateral Therapy	15 minutes
Intensive In-Home Therapy	15 minutes
Home Visit Service	15 minutes
Emergency Service	15 minutes
Personal Care Home	15 minutes

Evaluations, Examinations, and Testing	15 minutes
Therapeutic Rehabilitation for Children	1 hour
Therapeutic Rehabilitation for Adults	1 hour
Chemotherapy Service	15 minutes
Physical Examinations	15 minutes

(2) Overpayments discovered as a result of audits shall be settled [~~in the usual manner, i.e.,~~] through recoupment or withholding.

(3) The vendor shall complete an annual cost report on forms provided by the cabinet not later than ninety (90) days from the end of the vendor's accounting year and the vendor shall maintain an acceptable accounting system to account for the cost of total services provided, charges for total services rendered, and charges for covered services rendered eligible recipients.

(4) Each community mental health center [~~provider~~] shall make available to the cabinet at the end of each fiscal reporting period, and at intervals as the cabinet may require, all patient and fiscal records of the provider, subject to reasonable prior notice by the cabinet.

(5) Payments due a [~~the~~] community mental health center shall be made at reasonable intervals but not less often than monthly.

Section 3. Nonallowable Costs. The cabinet shall not make reimbursement under the provisions of this administrative regulation for services not covered by 907 KAR 1:044, community mental health center services, nor for that portion of a community mental health center's costs found unreasonable or nonallowable in accordance with the [~~"Cabi-~~

~~net for Human Resources~~] "Community Mental Health - Mental Retardation Reimbursement Manual."

Section 4. Reimbursement of Out-of-state Providers. Reimbursement to participating out-of-state community mental health centers [~~center providers~~] shall be the lower of charges, or the facility's rate as set by the state Medicaid Program in the other state, or the upper limit for that type of service in effect for Kentucky providers.

Section 5. Outpatient Access Support Adjusted Payment. (1) For a service provided during the period beginning October 1, 2002 and ending June 30, 2004, the department shall make an adjusted payment.

(2) An adjusted payment shall:

(a) Be made quarterly; and

(b) Be the difference between the costs as reported on the audited cost report ending June 30, 2000 and current costs.

(3) Current costs shall be calculated as follows:

(a) Using the audited cost report ending June 30, 2000, costs shall be allocated to the following cost centers:

1. Therapeutic rehabilitation;

2. Outpatient individual;

3. Outpatient group;

4. Outpatient psychiatry;

5. Outpatient in personal care home;

6. Outpatient in home setting; and

7. Hospital psychiatric;

(b) The Medicaid percentage for each cost center shall be determined by dividing the cost center's Medicaid units of service by its total units of service;

(c) Medicaid costs per cost center shall be determined by multiplying the cost center's total costs by its Medicaid percentage;

(d) Medicaid costs per cost center shall be inflated to the mid-point of the rate year using the Home Health Agency Market Basket, based on the "Health Care Cost Review" First (1st) Quarter State Fiscal Year (SFY) 2003; and

(e) Include an increase in capital from the cost report ending June 30, 2000 to cost report ending June 30, 2002 and the cost report ending June 30, 2003.

Section 6. Appeal Rights. A provider may appeal a Department for Medicaid Services decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.

Section 7. Incorporation by Reference.

(1) The "Community Mental Health - Mental Retardation Reimbursement Manual, July 2003 edition", is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky, 40621, Monday through Friday, 8:00 a.m. to 4:30 p.m.

CABINET FOR HEALTH SERVICES

Department for Medicaid Services

Division of Physicians and Specialty Services

(Emergency Amendment)

907 KAR 3:170E. Telehealth services and reimbursement.

RELATES TO: KRS 11.550, [~~194A.030(3),~~] 194A.060, 205.560, 422.317, 434.840 – 860, 42 CFR 415.152, 415.174, 415.184, 431 Subpart F, 440.50

STATUTORY AUTHORITY: KRS 194A.030(2) 194A.050 (1), 205.520(3), 205.559(7), 205.560

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.559 establishes the requirements regarding Medicaid reimbursement of telehealth providers. This administrative regulation establishes the coverage provisions relating to telehealth services and the method of determining reimbursement for services by the Department for Medicaid Services in accordance with KRS 205.559.

Section 1. Definitions. (1) "Consultation" means a type of evaluation and management service as defined by Current Procedural Terminology, CPT 2003 [~~2001~~] edition or the annual replacement revision upon its adoption by the department.

(2) "CPT code" means a code used for reporting procedures and services performed by physicians and published by the American Medical Association in Current Procedural Terminology, CPT 2003 [~~2001~~] edition or the annual replacement revision upon its adoption by the department.

(3) "Department" means the Department for Medicaid Services or its designated agent.

(4) “GT modifier” means a modifier that identifies a telehealth service which is approved by the healthcare common procedure coding system (HCPCS).

(5) [~~(4)~~] "Health care provider" means a:

(a) Licensed physician;

(b) Licensed advanced registered nurse practitioner;

(c) Certified physician assistant working under physician supervision;

(d) Licensed dentist or oral surgeon; or

(e) Licensed CMHC. [~~licensed physician, a licensed advanced registered nurse practitioner, a certified physician assistant working under supervision, or a licensed dentist or oral surgeon.~~]

(6) [~~(5)~~] "Hub site" means a telehealth site where the medical specialist providing the telehealth service is located and is considered the place of service.

(7) [~~(6)~~] "KenPAC" means the Kentucky Patient Access and Care system.

(8) [~~(7)~~] "KenPAC PCCM" means a Medicaid provider who is enrolled as a primary care case manager in the Kentucky Patient Access and Care System.

(9) [~~(8)~~] "Legally-authorized representative" means a recipient’s parent or guardian if a recipient is a minor child, or a person with power of attorney for a recipient.

(10) “Licensed community mental health center” or “licensed CMHC” means a facility that provides a comprehensive range of mental health services to recipients of a designated area in accordance with KRS 210.370 to 210.480.

(11) [~~(9)~~] "Medical necessity" or "medically necessary" means a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(12) [~~(10)~~] "Medical specialist" means a physician specialist, [~~or~~] an oral surgeon, or a CMHC as specified in Section 4[~~2~~](1) of this administrative regulation.

(13) [~~(11)~~] "Spoke site" means a telehealth site where the recipient receiving the telehealth service is located.

(14) [~~(12)~~] "Telehealth service" means a medical service provided through advanced telecommunications technology from a hub site to a recipient at a spoke site.

(15) [~~(13)~~] "Telehealth site" means a hub site or spoke site that has been approved as part of a telehealth network established in accordance with KRS 11.550.

(16) [~~(14)~~] "Transmission cost" means the cost of the telephone line and related costs incurred during the time of the transmission of a telehealth service.

(17) [~~(15)~~] "Two (2) way interactive video" means a type of advanced telecommunications technology that permits a real time service to take place between a recipient and a telepresenter at the spoke site and a medical specialist at the hub site.

Section 2. Covered Services. (1) Except as restricted in accordance with Section 3 of this administrative regulation, a telehealth service shall be covered if medically necessary.

(2) A telehealth service shall require:

(a) The use of two (2) way interactive video;

(b) A referral by a health care provider specified in section 4(2) of this administrative regulation;

(c) A referral by a recipient's KenPAC PCCM if the comparable nontelehealth service requires a KenPAC PCCM referral; and

(d) A referral by a recipient's lock-in provider if the recipient is locked-in pursuant to 42 CFR 431.54 and 907 KAR 1:677.

Section 3. Limitations. (1) Coverage of telehealth services for a non-CMHC shall be limited to a maximum of four (4) telehealth services per recipient per year if provided as follows [~~in accordance with paragraph (a) or (b) of this subsection~~]:

(a) For a recipient [~~Recipients~~] age twenty-one (21) years and older, the evaluation and management consultation CPT codes 99241 through 99275 may be billed as a telehealth service if provided by a medical specialist specified in Section 4(1) of this administrative regulation; or [~~.~~]

(b) For a recipient [~~Recipients~~] under the age of twenty-one (21) years:

1. The evaluation and management consultation CPT codes 99241 through 99275 may be billed as a telehealth service if provided by a medical specialist specified in Section 4(1) of this administrative regulation; and

2. Psychiatric diagnostic evaluation CPT code 90801 and individual psychotherapy CPT codes 90804 through 90809 may be billed as a telehealth service if provided by a psychiatrist.

(2) Coverage for a telehealth service for a licensed CMHC shall be limited to twelve (12) psychiatric services per recipient per year and shall be billed using the following diagnostic CPT service codes:

1. 90801 for a diagnostic interview examination;

2. 90862 for medication management;

3. 90887 for an outpatient collateral;

4. 90804 for an individual psychotherapy; or

5. 90847 for an outpatient family therapy.

(3) [~~(2)~~] Coverage shall not be provided for a service that requires face-to-face contact with a recipient in accordance with 42 CFR 447.371.

Section 4. Eligible Providers. (1) A [~~The~~] medical specialist at a [~~the~~] hub site shall be enrolled as a Medicaid provider pursuant to 907 KAR 1:671 and 907 KAR 1:672 and shall be:

(a) For a non-CMHC a licensed physician in one of the following specialties or subspecialties:

1. Dermatology;

2. Emergency medicine;

3. An internal medicine subspecialty;

4. General surgery or a surgery subspecialty;

5. Neurology;

6. Obstetrics and gynecology;

7. A pediatric subspecialty;

8. Psychiatry; [~~or~~]

9. Radiology or radiation medicine; or

10. [~~(b)~~] A licensed oral surgeon; or

(b) For a licensed CMHC:

1. A psychiatrist; or

2. An advanced registered nurse practitioner.

(2) A [~~The~~] health care provider requesting a telehealth service shall be an enrolled Medicaid provider who is a:

(a) Licensed physician;

(b) Licensed advanced registered nurse practitioner;

(c) Certified physician assistant working under physician supervision; [~~or~~]

(d) Licensed dentist or oral surgeon; or [~~.~~]

(e) A licensed CMHC.

Section 5. Reimbursement. (1) The department shall reimburse a medical specialist located at a [~~the~~] hub site for a telehealth service:

(a) An amount equal to the amount paid for a comparable in-person service in accordance with 907 KAR 3:010; or [~~.~~]

(b) If a licensed CMHC, in accordance with 907 KAR 1:045.

(2) A medical specialist shall bill for a service using the appropriate evaluation and management CPT code as specified in Section 4 of this administrative regulation with the addition of the two (2) letter "GT" modifier.

(3) The department shall not require the presence of a [~~the~~] health care provider requesting a [~~the~~] telehealth service at the time of the telehealth service unless it is requested by a [~~the~~] medical specialist at the hub site.

(4) Reimbursement shall not be made for transmission costs.

Section 6. Confidentiality and Data Integrity. (1) [~~Confidentiality laws and other requirements that apply to written medical records shall apply to electronic medical rec-~~

~~ords and telehealth services.~~]

[~~(2)~~] A telehealth service shall be performed on a secure telecommunications line or utilize a method of encryption adequate to protect the confidentiality and integrity of the telehealth service information.

(2) [~~(3)~~] Both a [~~the~~] hub site and a [~~the~~] spoke site shall use authentication and identification to ensure the confidentiality of a [~~the~~] telehealth service.

(3) [~~(4)~~] A provider of a telehealth service shall implement confidentiality protocols that include:

(a) Identifying personnel who have access to a telehealth transmission;

(b) Usage of unique passwords or identifiers for each employee or person with access to a telehealth transmission; and

(c) Preventing unauthorized access to a telehealth transmission.

(4) [~~(5)~~] A provider's protocols and guidelines shall be available for inspection by the department upon request.

Section 7. Informed Consent. (1) Before providing a telehealth service to a recipient, a [~~the~~] health care provider shall document written informed consent from the recipient and shall ensure that the following written information is provided to the recipient in a format and manner that the recipient is able to understand:

(a) The recipient shall have the option to refuse the telehealth service at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of a Medicaid benefit to which the recipient is entitled;

(b) The recipient shall be informed of alternatives to the telehealth service that are available to the recipient;

(c) The recipient shall have access to medical information resulting from the telehealth service as provided by law;

(d) The dissemination, storage, or retention of an identifiable recipient image or other information from the telehealth service shall not occur without the written informed consent of the recipient or the recipient's legally-authorized representative;

(e) The recipient shall have the right to be informed of the parties who will be present at the spoke site and the hub site during the telehealth service and shall have the right to exclude anyone from either site; and

(f) The recipient shall have the right to object to the video taping of a telehealth service.

(2) A copy of the signed informed consent shall be retained in the recipient's medical record and provided to the recipient or the recipient's legally-authorized representative upon request.

(3) The requirement to obtain informed consent before providing a service shall not apply to an emergency situation if the recipient is unable to provide informed consent and the recipient's legally-authorized representative is unavailable.

Section 8. Medical Records. (1) A request for a telehealth service from a physician or other health care provider specified in Section 4(2) of this administrative regulation and the medical necessity for the telehealth service shall be documented in the recipient's medical record.

(2) A health care provider shall keep a complete medical record of a telehealth service provided to a recipient and follow applicable state and federal statutes and regulations for medical recordkeeping and confidentiality in accordance with KRS 194A.060,

422.317, 434.840 – 860, and 42 CFR 431 Subpart F.

(3) A medical record of a telehealth service shall be maintained in compliance with 907 KAR 1:672.

(4) Documentation of a [~~the~~] telehealth service by the referring health care provider shall be included in the recipient's medical record and shall include:

(a) The diagnosis and treatment plan resulting from the telehealth service and a progress note by the referring health care provider if present at the spoke site during the telehealth service;

(b) The location of the hub site and spoke site;

(c) A copy of the signed informed consent form; and

(d) Documentation supporting the medical necessity of the telehealth service.

(5) A [~~The~~] medical specialist's diagnosis and recommendations resulting from a [~~the~~] telehealth service shall be documented in the recipient's medical record at the recipient's location. The medical specialist shall send a written report to the referring health care provider.

Section 9. Appeal Rights. (1) An appeal of a department determination [~~negative action taken by the department~~] regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

(2) An appeal of a department determination [~~negative action taken by the department~~] regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) A provider may appeal a department decision as to the application of this administrative regulation [~~An appeal of a negative action taken by the department regarding a~~

~~Medicaid provider shall be~~] in accordance with 907 KAR 1:671.